Supreme Court, U. S.
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No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY MEMORANDUM FOR PETITIONER

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I.

RESPONDENTS' ATTEMPT TO CLOUD THE RECORD FLIES IN THE FACE OF THEIR OWN CONCESSIONS AND THE RULINGS OF THE LOWER COURTS AND MISPERCEIVES THE RATIONALE OF THE *PER SE* RULE

Respondents' efforts to cloud the factual record is a traditional tactic in opposing a petition for a writ of certiorari, but their efforts are refuted by their own concessions. Respondents themselves admit, "[T]he undisputed facts established an agreement among physicians who are members of a medical foundation that . . . each would accept as payment in full the amount paid by . . . insurance [endorsed

by that medical foundation]."[1] The foundations' endorsement turns on acceptance of the foundations' fee schedules (Jt. Br. in Opp. at 4), and under the foundations' by-laws their members "vote on the adoption of ... [those] uniform fee schedules."[2] The record is sufficiently clear therefore to warrant issuing the writ of certiorari.

The lower courts were unanimous in recognizing that what is involved here is a precise question of law and not—as respondents would have it—the adjudication of a factual dispute. The District Court, after all, certified its decision for interlocutory appeal under 28 U.S.C. § 1292(b) saying, "This Court's determination that the Rule of Reason approach should be used ... to determine whether a violation of Section 1 of the Sherman Act has occurred involves a question of law as to which there is substantial ground for difference of opinion ...."[3] The Court of Appeals unanimously accepted the section 1292(b) appeal, though it restated slightly the District Court's formulation of the issue: "[W]hether the [foundation] membership agreements, which contain the promise to abide by maximum fee schedules, are illegal *per se* under section 1 of the Sherman Act, 15 U.S.C. § 1." Pet. App. A at 2.

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[1] Joint Brief in Opposition to the State of Arizona's Petition for a Writ of Certiorari at *i* (hereinafter Jt. Br. in Opp.)

Respondents refer repeatedly to payments by health insurers and, while this is a convenient shorthand, it is somewhat lacking in precision. Under foundation-endorsed health plans, payments might be made either by health insurance companies or by major employers such as Motorola, Inc. or the State of Arizona which are sufficiently large that they do not need an intermediate insurance company to underwrite the actuarial risk. In any event, the foundation-endorsed health plans have deductible limits which must be met by the patient before any third-party reimbursement is made and payments against the deductible limits are made directly by the patients and not by any third-party.

[2] CR 106, Nos. 12, 13, 20, 21, 27, 28, 29.

[3] Petition for a Writ of Certiorari, Appendix F at 50 (hereinafter Pet. App.).

The section 1292(b) certifications by the lower courts are consistent with the traditional place of the *per se* rule in our antitrust jurisprudence. Beginning with *Standard Oil Co. v. United States*, 221 U.S. 1 (1911), and as recently as *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), this Court has consistently held that certain agreements are so patently anticompetitive that no elaborate inquiry is required to hold them unlawful. This is the essence of the *per se* rule.

It may well be that the "uniform fee schedules" voted upon by the foundations' members are lower than those used by some health insurers and higher than those used by others. *See* Jt. Br. in Opp. at 11. Under the rule of reason and the *per se* rule, however, there must be the threshhold inquiry whether consideration of other fee schedules is necessary to decide the legality of the fee schedules agreed upon and used by the respondents and their members. So, too, with the matter of the competitive interaction of hospitals and health maintenance organizations, for example, and questions such as whether respondents have exacted the full measure of monopoly profits. *See* Jt. Br. in Opp. at 11. Concededly, none of these matters has been explored definitively in the present record, but the proper inquiry under the *per se* rule is whether analysis of these matters is necessary in order to judge the legality of respondents' adoption and use of agreed-upon fee schedules.

At least this much is clear and undisputed in the present record. Respondents and their members establish fee schedules for the individual medical services performed by respondents' members. Respondents' members are paid in

accordance with those agreed-upon fee schedules.[4] The issue which this Court must decide is whether those facts are sufficient to establish a *per se* violation of the Sherman Act or whether it is necessary to examine the full spectrum of the medical marketplace in order to rule respondents' conduct unlawful.

II.

THE NINTH CIRCUIT UNMISTAKEABLY RULED THAT THE REASONABLENESS OF AN AGREED-UPON PRICE IS A DEFENSE TO A PRIICE-FIXING CHARGE AND THIS RULING CREATES A CONFLICT WITH THE DECISIONS OF THIS COURT AND THE OTHER COURTS OF APPEALS WHICH SHOULD BE RESOLVED BY THIS COURT.

There is no question that this Court and the Courts of Appeals other than the Ninth Circuit have consistently rejected any defense to price-fixing charges based on the alleged reasonableness of the agreed-upon price. Perhaps recognizing that the Ninth Circuit's acceptance of such a defense would be grounds for summary reversal, respondents attempt to deny that the Ninth Circuit made any such ruling: "It did not rely on a reasonableness of price defense." Jt. Br. in Opp. at 13. With all due respect, it takes no more than a cursory review of the Ninth Circuit opinion

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[4] Respondents argue that "[t]his action does *not* involve an agreement by doctors on prices to charge their patients ...." Jt. Br. in Opp. at 1. The distinction respondents seem to be making is that they have agreed upon the "level of reimbursement," *e.g.*, *id.*, at 3, or the amount they will be paid by their patients and third-party payors rather than upon the prices they charge those patients and third-parties. This is a distinction without a difference.

If anything, the distinction respondents seek to draw is suggestive of greater price uniformity. In *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950), the prescribed rates from the fee schedule were used in the great majority of transactions, although in exceptional circumstances a lower charge was made. Where, as here, the agreement is on the level of reimbursement rather that the quoted price, there is eliminated any incentive to deviate from the agreed-upon price even in "exceptional circumstances."

to demonstrate that the reasonableness of the agreed-upon price was, in fact, accepted as a defense to a price-fixing charge and that this aberrational ruling must be reviewed by this Court.

Contrary to respondents' argument, Judge Sneed did say, "The relevant inquiry becomes whether fees paid to doctors under that system would be less than those payable under the [foundations'] maximum fee agreement." Pet. App. A at 6. To make this "relevant inquiry," Judge Sneed suggested comparisons with other fee schedules used in the medical marketplace (Pet. App. A at 8-9); an analysis of respondents' own fee schedules to determine whether they were so high as "to capture a greater share of potential monopoly profit" (*id.*, at 6) or "sufficiently low to discourage entry by potential competitors" (*id.*, at 9); and a comparison of "the present supply and demand functions and those which would exist under ideal competitive conditions." *Id.*, at 6. All of these inquiries go to the reasonableness of the prices respondents have agreed upon. An analysis whether respondents' prices are "too high" or "too low" can have no purpose other than determing whether respondents' prices are reasonable. In the face of such explicit statements by Judge Sneed, respondents cannot argue that he "did not rely on a reasonableness of price defense."

The defense which the Ninth Circuit has allowed only serves to underscore the practical wisdom which has led this Court and every other Court of Appeals to reject the reasonableness of the price defense. It may be that the foundations' fee schedules implicated here are lower than

those that physicians have agreed upon for Blue Shield[5] or that the foundations themselves carry out in the State of Arizona's foster children program, but until now no antitrust defendant has ever been allowed to defend on the basis that some other conspiracy has established a still higher level of agreed-upon prices. This Court should reject this unprecedented defense recognized by the Ninth Circuit.

III.

IN LIGHT OF THEIR OWN CONCESSIONS AND THE FINDINGS OF THE LOWER COURTS, IT IS TOO LATE FOR RESPONDENTS TO ARGUE THAT THEIR AGREEMENTS ARE NOT AT LEAST MAXIMUM PRICE-FIXING.

In much the same vein as they argue that the Ninth Circuit did not endorse the reasonable price defense, respondents also argue that the lower courts "did not have to decide if horizontal price-fixing agreements that establish maximum prices constitute a *per se* violation." Jt. Br. in Opp. at 21. In light of their arguments to the lower courts and the findings of those courts, it is disingenuous for respondents to claim that the lower courts did not decide this question.

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[5] Justice Stewart's majority opinion in *Group Life & Health Ins. Co. v Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979) noted,

> Recent studies have concluded that physicians and other health care providers typically dominate the Boards of Directors of Blue Shield plans. Thus there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health care costs to the detriment of consumers generally.

With a cloud already hanging over the legality and reasonableness of Blue Shield's fee schedules, the Blue Shield fee schedules are hardly a reliable benchmark for judging the legality or reasonableness of respondents' fee schedules.

In the District Court, for example, respondents relied heavily upon the affidavit of their executive director Anthony D. Mitten to show that their agreement set maximum fees.[6] The District Court accepted this argument. It said, "Based on the affidavit of Anthony D. Mitten, it is clear that the defendant Maricopa Foundation for Medical Care ... sets the maximum fees," Pet. App. D at 42, but the Court perceived "a recent antitrust trend ... emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust law," *id.*, at 43, and therefore declined to apply this Court's *per se* rulings in *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951), and *Albrecht v. Herald Co.*, 390 U.S. 145 (1968). Pet. App. D at 44.

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[6] We assume, for the sake of argument, that respondents' fee schedules set maximum rather than minimum fees, but there is much to argue that what is involved here is a minimum or uniform fee schedule. This Court, in *Albrecht v. Herald Co.*, 390 U.S. 145, 153 (1968), affirmed the principle that so-called ceilings on prices easily become floors:

> Moreover, if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, which is increasingly likely, as the maximum price approaches the actual cost of the dealer, the scheme tends to acquire all the attributes of an arrangement fixing minimum prices.

The record here is clear that the purpose of the letters, polls and meetings among the foundations and their members was to set one price for any given service. For example, a letter from Maricopa Foundation for Medical Care's president, Dr. Lawrence J. Shapiro admits, "The Maricopa Foundation For Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area." CR 7(b) Exhibit MF-33. (Appendix A hereto.) *See also* CR 7(b) Exhibits MF-3, MF-6 (Appendices B and C hereto) for further examples of the manner in which prices were set.

The result was the same in the Ninth Circuit. Before that Court, respondents argued that the maximum prices they had agreed upon were reasonable.[7] The Ninth Circuit accepted the District Court's finding that this was a "maximum fee agreement," Pet. App. A at 6, but declined to apply *Kiefer-Stewart* and *Albrecht* to this agreement, saying, "This circuit has not extended those rulings to horizontal agreements that establish maximum prices." Pet. App. A at 7 n.4. It is incorrect, then, to argue that the lower courts did not "decide if horizontal price-fixing agreements that establish maximum prices constitute a *per se* violation." Both of the lower courts did decide this question and they decided it contrary to the decisions of this Court and the other Courts of Appeals. Indeed, both of the lower courts expressly refused to follow this Court's decisions in *Kiefer-Stewart* and *Albrecht*.

IV.

THE NINTH CIRCUIT HAS CREATED A SPECIAL EXEMPTION FROM THE ANTITRUST LAWS FOR PHYSICIANS, AND THIS COURT MUST RESOLVE THE CONFLICT AMONG THE CIRCUITS.

The foundations' argument that the Ninth Circuit's decision does not impose a unique exemption for doctors and the health industry ignores the singular approach to price-fixing analysis taken by Judge Sneed for this industry:

> The health care industry, moreover, presents a particularly difficult area. The first step to understanding is to recognize that not only is access to the medical profession very time consuming and expensive both for

[7] "[T]he uncontroverted evidence establishes that at no time has Maricopa Foundation set a maximum reimburseable level of compensation for medical services ... in excess of what Maricopa Foundation's Board of Trustees believed to be the prevailing average or median usual and customary fee charged by physicians in Maricopa County for their services." Brief of Defendant-Appellee Maricopa Foundation for Medical Care at 28, *citing* CR 57, Mitten Affidavit, ¶ 6.

> the applicant and society generally, but also that numerous government subventions of the costs of medical care have created both a demand and supply function for medical services that is artificially high.

Pet. App. A at 6. Such solicitude for the particulars of an industry is not present in any other price-fixing case. *E.g., United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 220 (1940) ("elimination of so-called competitive evils is no legal justification"). Certainly, the expense and time of entering the legal profession did not prevent this Court from finding in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 782-83 (1975), that "respondents' activities constitute a classic illustration of price fixing." As Judge Larson noted his dissent below, "[T]he situation with which the Court was confronted in *Goldfarb* — price fixing — is the same practice challenged in this case." Pet. App. at 21.

Moreover, the respondent foundations' only argument in rebuttal to petitioner's showing of a conflict between the Ninth Circuit's decision and the other Circuits is to say that there is not sufficient evidence in the record from which to find a *per se* violation. Jt. Br. in Opp. at 23. Such a position cannot stand in light of both the record in this case and the proper application of the *per se* rule. *See* section II, *supra*.

Contrary to the foundations' bald assertion that the circuits are not in conflict as a result of the Ninth Circuit's opinion, two recent cases demonstrate that the controversy is current and ongoing. In *Williams v. St. Joseph Hospital*, [1980-2] CCH Trade Cas. ¶63,438, at 76,290 (7th Cir. 1980), the Seventh Circuit, citing *Goldfarb*, stated that "later cases indicate plainly that with regard to its economic aspects professional activity is subject to the policies of the antitrust laws." In addition, the Second Circuit just recently upheld the Federal Trade Commission's restrictions on physician advertising, *American Medical Association v. Federal Trade Commission*, [1980-2] CCH Trade Cas.

¶63,568 (2d Cir. 1980), which restrictions are grounded on basic antitrust conspiracy law as set forth in *Goldfarb*. In the *Matter of American Medical Association*, CCH Trade Reg. Rep. ¶21,068 (1979).

CONCLUSION

For the reasons set forth herein and in the petition, the petition for writ of certiorari should be granted.

Respectfully submitted,

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Antitrust Division

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Counsel for Petitioner

Appendix A

M[illegible]RICOPA FOUNDATION FOR ME[illegible]AL CARE

ACADEMY OF MEDICINE
2601 NORTH CENTRAL AVENUE
PHOENIX, ARIZONA 85004

TELEPHONE: [illegible]

President
Lawrence J. Shapiro, M.D.
Vice President
William Myers, M.D.
LeRoy P. Graves, D.C.
Treasurer
Rodger Hart, M.D.
Secretary
Patrick P. Moreno, M.D.
Trustees
Joseph Bier, M.D.
Norman Brown, M.D.
James Campbell, M.D.
William Cook, M.D.
Richard Daley, M.D.
Robert Disarro, M.D.
Robert L. Fox, M.D.
James Giangobbe, M.D.
Keith Harris, M.D.
David Hirshorn, M.D.
James Loughorn, M.D.
Donald Miles, M.D.
Laurence Nolan, M.D.
Richard Pennington, M.D.
William Ragsdale, M.D.
Ronald Surer, M.D.
Executive Director
Anthony D. Moran, J.D.
Administrative Director
Bruce M. Lefler

April 14, 1977

Truman Plainer, M.D.
President
Arizona Ophthalmological Society
2600 South Rural Road
Tempe, Arizona 85282

Dear Doctor Plainer:

The Maricopa Foundation For Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area.

To that end we would ask you to review with members of your specialty group the present Foundation conversion factors (attached) and advise us as to any changes you feel would be appropriate either on an overall conversion factor change or specific procedures where your group feels the payments are inequitable.

We hope by these means to keep the Foundation concept viable in this community in protecting the private practice, free choice of physician method of health care delivery.

We would appreciate receiving this information from your organization by June 10, 1977.

Sincerely,

Lawrence J. Shapiro, M.D.
PRESIDENT

LJS/jtm

Established as a service to the community by the Maricopa County Medical Society

EXHIBIT NO. ME-33

Appendix B

MARICOPA FOUNDATION FOR MEDICAL CARE

ACADEMY OF MEDICINE
[redacted] NORTH CENTRAL AVENUE
PHOENIX, ARIZONA [redacted]

TELEPHONE [redacted]

President
[redacted]
Vice Presidents
[redacted]
Treasurer
[redacted]
Secretary
[redacted]
Trustees
[redacted]
Executive Director
[redacted]
Administrative Director
[redacted]

June 7, 1977

To: All Foundation Members

Dear Doctor:

The Foundation is in the process of reviewing its Minimum Standards and we feel it is time to survey the entire Foundation membership for their opinions concerning our fee schedule. While we do not feel that the Foundation Fee Schedule can be considered usual and customary for this area we do feel strongly that it should approximate the majority of physician charges.

In order to arrive at a reasonable consensus we need your prompt response to the enclosed post card questionnaire. As soon as we tabulate this poll you will receive a ballot asking for your approval of any changes in the Foundation Fee Schedule.

We appreciate your early response to this questionnaire and look forward to your continued support and cooperation.

Sincerely,

Lawrence J. Shapiro, M.D.
PRESIDENT

LJS/jtm

Enclosure

Established as a service to the community by the Maricopa County Medical Society

EXHIBIT NO. ME-3

Appendix C

UROLOGY ASSOCIATES, LTD
FIFTH AVENUE MEDICAL BUILDING
PHOENIX, ARIZONA

May 26, 1977

Lawrence J. Shapiro, M.D.
President, Maricopa Foundation for Medical Care
2025 North Central Avenue
Phoenix, Arizona 85004

Dear Larry:

This is in response to your letter to me as President of the Phoenix Urological Society in reference to the customary charges of urologists in this community.

I did not really know how to answer this, short of polling the members at our meeting two days ago as to what their usual and customary charges were. Using the equivalent of the '64 California Relative Value Scale, most of the physicians were 10 to 11 with a few at 12, and only one physician was 9.5.

I think without reservation one could say that your present charge of 9.5 dollars per unit is less than what most physicians are presently charging.

The one operation that most urologists feel is inadequately reimbursed is the Marshall-Marchetti procedure which is allowed 40 units, and most physicians are charging 60 units, based on the fee schedule of the AUA, which in most procedures is essentially the same as the '64 California Relative Value Scale.

Hoping the above answers your questions,

Sincerely yours,

Sherwood E. Denton, M.D.

SED:mh

EXHIBIT NO. ME-6